MANAGEMENT

1.0. UTILIZATION MANAGEMENT PROGRAM PLAN

1.1. These requirements are applicable to utilization and quality review of all health care services delivered to beneficiaries living within the Region, to all beneficiaries receiving care in the Region regardless of their place of residence, and to all providers delivering care within the Region. Additional requirements for enrollees (such as authorizations for specialty care) and network providers (such as qualifications to be network providers) are further identified in Chapter 5. All providers shall be subject to the same review standards and criteria. The contractor shall be considered a multi-function Peer Review Organization under this contract.

1.2. The contractor shall fully describe in a written Utilization Management Plan all processes, procedures, criteria, staff and staff qualifications, and information and data collection activities and requirements the contractor shall use in conducting utilization management activities including utilization reviews, discharge planning, disease management programs, demand management programs or other techniques employed by the contractor to exercise clinical oversight. The contractor's plan shall delineate the organizational structure, responsibilities and authorities of personnel involved in the performance of utilization management activities, and specifically describe how the utilization management requirements of the contract will be accomplished.

1.3. The Utilization Management Program Plan shall be approved by the Contracting Officer. The finalized plan shall be submitted through the appropriate Regional Director to the Contracting Officer for approval. The Contracting Officer will provide the contractor with written approval within 30 calendar days of receipt of the plan.

1.4. The contractor shall establish and document in the Utilization Management Program Plan specific, measurable goals for the evaluation of the overall effectiveness of the Utilization Management Program. Additionally, the contractor shall establish goals and thresholds for the internal monitoring and improvement of the Utilization Management Program as well as program components for measuring the improvements.

1.5. The contractor, Regional Director, and Contracting Officer shall review the plan annually. Revisions to the plan, if any, shall be submitted for approval through the Regional Director to the Contracting Officer prior to the start of each option period. The contractor shall submit any revised plan to the Regional Director at least 90 calendar days prior to the beginning of each option period.

2.0. NOTIFICATION OF REVIEW REQUIREMENTS

The contractor is responsible for education and training to providers and beneficiaries on the requirements of the utilization management programs. The contractor shall describe fully the process for notification in a timely manner (but not less than 30 calendar days prior to commencement of review) of all providers, both network and non-network, of all review requirements such as preauthorization, concurrent review, retrospective review (including the fiscal penalties for failing to obtain review authorizations), review criteria to be used, and requirements for case management.

3.0. REVIEWER QUALIFICATIONS AND PARTICIPATION

3.1. Peer Review By Physicians

3.1.1. Except as provided in paragraph 3.1.2., each person who makes an initial denial determination about services furnished or proposed to be furnished by a licensed doctor of medicine or osteopathy or by a doctor of dentistry must be respectively another licensed doctor of medicine or osteopathy or of dentistry with an active clinical practice in the PRO area*, if the initial determination is based on lack of medical necessity or other reason relative to reasonableness, necessity or appropriateness*.

3.1.2. If a PRO determines that peers are not available to make initial denial determinations, a doctor of medicine or osteopathy may make denial determinations for services ordered or performed by a doctor in any of the three specialties.

3.2. Peer Review By Health Care Practitioners Other Than Physicians

Health care practitioners other than physicians may review services furnished by other practitioners in the same professional field.

3.3. DRG Validation Review

Decisions about procedural and diagnostic information must be made by physicians. Technical coding issues must be reviewed by individuals with training and experience in ICD-9-CM coding.

3.4. Persons Excluded From Review

3.4.1. A person may not review health care services or make initial denial determinations or changes as a result of DRG validations if he or she, or a member of his or her family, (1) participated in developing or executing the beneficiary's treatment plan, (2) is a member of the beneficiary's family; or (3) is a governing body member, officer, partner, five percent or more owner, or managing employee in the health care facility where the services were or are to be furnished.

3.4.2. A member of a reviewer's family is a spouse (other than a spouse who is legally separated under a decree of divorce or separate maintenance), child (including a legally adopted child), grandchild, parent, or grandparent.

3.5. Administrative Requirements

Each review shall be dated and include the signature, legibly printed name, clinical specialty, and credentials of the reviewer. Each reviewer shall include rationale for his or her decision (i.e., a complete statement of the evidence and the reasons for the decision).

4.0. WRITTEN AGREEMENTS WITH INSTITUTIONAL PROVIDERS

The contractor shall establish written agreements with each institutional provider over which the contractor has review authority. These agreements shall be in place before the start of services. Agreements must specify that:

- Institutional providers will cooperate with the contractor in the assumption and conduct of review activities.
- Institutional providers will allocate adequate space for the conduct of on site review.
- Institutional providers will photocopy and deliver to the contractor all required information within 30 calendar days of a request for off-site review.
- Institutional providers will provide all beneficiaries, in writing, their rights and responsibilities (e.g., "An Important Message from TRICARE" (Chapter 7, Addendum A), "Hospital Issued Notice of Noncoverage" (Chapter 7, Addendum B).
- Institutional providers will inform the contractor within three working days if they issue a notice that the beneficiary no longer requires inpatient care.
- Institutional providers will assure that each case subject to preadmission/ preprocedure review has been reviewed and approved by the contractor.
- Institutional providers will agree, when they fail to obtain certification as required, they will accept full financial liability for any admission subject to preadmission review that was not reviewed and is subsequently found to be medically unnecessary or provided at an inappropriate level. (32 CFR 199.15(g))
- The contractor shall reimburse the provider for the costs of photocopying and postage using the same reimbursement as Medicare.
- The contractor shall provide detailed information on the review process and criteria used, including financial liability incurred by failing to obtain preauthorization.

5.0. BENEFIT POLICY DECISIONS

5.1. TRICARE Versus Local Policy

TRICARE policies have precedence over any local or internal policy of the contractor or the medical community of the region where non-Prime enrollees are involved. However, the contractor shall notify TMA promptly or any conflicts between TRICARE policy and local policy. For TRICARE Prime enrollees, variations from policy which simply expand coverage may be implemented without prior approval, but TMA must be notified of enhanced coverage at least 30 days prior to implementation. If benefits are being reduced or adjusted, the change shall be referred to TMA for approval before being implemented.

5.2. TRICARE Policy Silent

When TRICARE is silent on an issue, the contractor shall extend benefits for medically necessary and appropriate care that represents the standard of practice in this country.

6.0. CONCURRENT REVIEW REQUIREMENTS

6.1. The contractor shall conduct concurrent review for continuation of inpatient mental health services within 72 hours of emergency admissions (see 32 CFR 199.4(b)(6)(iv)), and authorize, as appropriate, additional days.

7.0. RETROSPECTIVE REVIEWS RELATED TO DRG VALIDATION

7.1. The contractor shall conduct quarterly focused reviews of a one percent sample of medical records to assure that reimbursed services are supported by documentation in the patient's medical record. This review must determine if the diagnostic and procedural information and discharge status of the patient as reported by the hospital matches the attending physician's description of care and services documented in the patient's record. In order to accomplish this, the contractor shall conduct the following review activities:

7.2. Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG (see Chapter 7, Addendum C).

7.3. Review for physician certification as to the major diagnosis and procedures and the physician's acknowledgment of a penalty statement on file.

7.4. When the claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice:

> "Notice to Physicians: TRICARE payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential

information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

7.5. The acknowledgment must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before, or at the time the physician admits his or her first patient. Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

7.6. Outlier Review

Claims that qualify for additional payment as a cost-outlier shall be subject to review to ensure that the costs were medically necessary and appropriate and met all other requirements for payment. In addition, claims that qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.

7.7. Procedures Regarding Certain Services Not Covered By The DRG-Based Payment System

In implementing the quality and utilization review for services not covered by the DRG-based payment system, the requirements of this section shall pertain except that ICD-9 and CPT-4 codes will provide the basis for determining whether diagnostic and procedural information is correct and matches information contained in the medical records.

8.0. RETROSPECTIVE REVIEW REQUIREMENTS FOR OTHER THAN DRG VALIDATION

The contractor shall conduct quarterly focused reviews of a one percent sample of medical records to determine the medical necessity and quality of care provided, validate the review determinations made by review staff, and determine if the diagnostic and procedural information and/or discharge status of the patient as reported on the hospital and/or professional provider's claim matches the attending physician's description of care and services documented in the medical record. The specific types of records to be sampled shall be determined separately by each Regional Director who will provide the contractor with the sampling criteria (DRG, diagnosis, procedure, length of stay, provider, incident or occurrence as reported on claim forms) 60 calendar days prior to the quarter from which the review sample is drawn. Within the parameters provided by each Regional Director, the contractor shall ensure that each sample is statistically valid. For all cases selected for retrospective review, the following review activities shall occur:

8.1. Admission Review

The medical record must indicate that inpatient hospital care was medically necessary and provided at the appropriate level of care.

8.2. Invasive Procedure Review

The performance of unnecessary procedures may represent a quality and/or utilization problem. In addition, the presence of codes of procedures often affects DRG classification. Therefore, for every case under review, the medical record must support the medical necessity of the procedure performed. For this purpose, invasive procedures are defined as all surgical and any other procedures which affect DRG assignment.

8.3. Discharge Review

Records shall be reviewed using appropriate criteria for questionable discharges or other potential quality problems.

8.4. Mental Health Review

The contractor shall review all mental health claims in accordance with the provisions in 32 CFR 199.4(a)(11) and (a)(12).

9.0. REVIEW RESULTS

9.1. Actions As A Result Of Retrospective Review Related To Individual Claims

If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results in the unnecessary admission of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the contractor shall, as appropriate:

- Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination;
- Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice;
- Advise the provider and beneficiary of appeal rights, as required by Chapter 13, Section 4, paragraph 2.0.

9.2. Findings Related To A Pattern Of Inappropriate Practices

The contractor shall notify TMA of the hospital and practice involved in all cases where a pattern of inappropriate admissions and billing practices that have the effect of circumventing the TRICARE DRG-based payment system is identified.

9.3. Revision Of Coding Relating To DRG Validation

The contractor shall ensure the application of the following provisions in connection with the DRG validation process.

- If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the TRICARE claim shall be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.

- If the information attested to by the physician as stipulated in paragraph 7.3. is found not to be correct, the contractor shall change the coding and assign the appropriate DRG on the basis of the changed coding in accordance with the paragraph above.

9.4. Notice Of Changes As A Result Of A DRG Validation

The contractor shall notify the provider and practitioner of changes to procedural and diagnostic information that result in a change of DRG assignment within 30 calendar days of the contractor's decision. The notice must be understandable and written in English and shall contain:

- The corrected DRG assignment;

- The reason for the change resulting from the DRG validation;

- A statement addressing who is liable for payment of denied services (e.g., a beneficiary will be liable if the change in DRG assignment results in noncoverage of a furnished service);

- A statement informing each party (or his or her representative) of the right to request a review of a change resulting from DRG validation in accordance with the provisions in paragraph 9.5.;

- The locations for filing a request for review and the time period within which a request must be filed; and

- A statement concerning the duties and functions of the multi-function PRO.

9.5. Review Of DRG Coding Change

9.5.1. A provider or practitioner dissatisfied with a change to the diagnostic or procedural coding information made by the contractor as a result of DRG validation is entitled to a review of that change if the change caused an assignment of a different DRG and resulted in a lower payment.A beneficiary may obtain a review of the contractor's DRG coding change only if that change results in noncoverage of a furnished service (see 42 CFR 473.15(a)(2)).

9.5.2. The individual who reviews changes in DRG procedural or diagnostic information shall be a physician, and the individual who reviews changes in DRG coding must be qualified through training and experience with ICD-9-CM coding.

9.5.3. Procedures described for reconsideration or reopening also apply to the contractor's review of a DRG coding change. (See Chapter 13, Section 5, paragraph 5.3. for additional information relating to the appeals process of DRG cases.) An initial change as a result of the DRG validation is final and binding unless that change is reviewed and revised in accordance with the procedures in Chapter 13, Section 5, paragraph 5.3. No additional review or appeal is available (see 42 CFR 473.15(c)).

10.0. PREPAYMENT REVIEW

10.1. The contractor shall establish procedures and conduct prepayment utilization review to address those cases involving diagnoses requiring prospective review, where such review was not obtained, to focus on program exclusions and limitations and to assist in the detection of and/or control of fraud and abuse. The contractor shall not be excused from claims processing cycle time standards because of this requirement.

10.2. The contractor shall perform prepayment review of all cases involving diagnoses requiring preauthorization where review was not obtained. No otherwise covered care shall be denied solely on the basis that authorization was not requested in advance, except for care provided by a network provider.

10.3. The contractor shall perform prepayment review of all DRG claim adjustments submitted by a provider which result in higher weighted DRGs.

10.4. Payment reduction for noncompliance with required utilization review procedures shall apply to any case in which a provider was required to obtain preauthorization or continued stay (in connection with required concurrent review procedures) approval; the provider failed to obtain the necessary approval, and the health care services were not disallowed on the basis of necessity or appropriateness. In a case described in this section, reimbursement will be reduced unless such reduction is waived by the contractor based on special circumstances. The amount of the reduction for TRICARE Standard providers will be ten percent of the amount otherwise allowable for services for which preauthorization (including preauthorization for continued stays in connection with concurrent review requirements) approval should have been obtained but was not obtained. The amount of this reduction for network providers shall be in accordance with the provider's contract with the contractor but not less than ten percent.

10.5. The amount of this reduction for a non-network attending physician shall be ten percent of the amount otherwise allowable for services for which preauthorization (including preauthorization for continued stays in connection with concurrent review requirements) approval should have been obtained but was not obtained. Payment reduction for network providers will be subject to the provisions of their respective contracts.

10.6. In the case of hospital admissions reimbursed under the DRG-based payment system, the reduction shall be taken against the percentage (between zero and 100 percent) of the total reimbursement equal to the number of days of care provided without preauthorization approval divided by the total length of stay for the admission.

10.7. In the case of institutional payments based on per diem payments, the reduction shall be taken only against the days of care provided without preauthorization approval.

10.8. For care for which payment is on a per service basis, the reduction shall be taken only against the amount that relates to the services provided without preauthorization approval.

10.9. Unless otherwise specifically provided under procedures issued by the Director, TMA, the effective date of any preauthorization approval shall be the date on which a properly submitted request was received by the review organization designated for that purpose.

10.10. The payment reduction set forth in this section may be waived by the contractor when the provider could not reasonably have been expected to know of the preauthorization requirement or some other special circumstances where the provider may not have known the requirements and that the contractor believes justifies the waiver.

10.11. Services for which payment is disallowed may not be billed to the patient or the patient's family.

11.0. CASE MANAGEMENT

Case management shall not be accomplished for beneficiaries eligible for Medicare Part A and Enrolled in Medicare Part B unless it is specifically contracted for inside an individual MTF or if the individual is part of the Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC).

12.0. CONFIDENTIALITY APPLICABLE TO ALL UTILIZATION MANAGEMENT ACTIVITIES, INCLUDING RECOMMENDATIONS AND FINDINGS

12.1. The contractor shall develop and implement procedures, processes, and policies that meet the confidentiality and disclosure requirements set forth in Title 10, U.S.C., Chapter 55, Section 1102; the Social Security Act, Section 1160, and implementing regulations at 42 CFR 476, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act (42 U.S.C. 290dd-2), the Privacy Act (5 U.S.C.552a), 32 CFR 199.15(j) and (l). Additionally, the contractor shall display the following message on all quality assurance documents:

> "Quality Assurance document under 10 U.S.C. 1102. Copies of this document, enclosures thereto, and information therefrom will not be further released under penalties of law. Unauthorized disclosure carries a possible $3,000 fine."

12.2. Release of Information - If an inquiry is made by the beneficiary, including an eligible family member (child) regardless of age, the reply should be addressed to the beneficiary, not the beneficiary's parent or guardian. The only exceptions are when a parent writes on behalf of a minor child or a guardian writes on behalf of a physically or mentally incompetent beneficiary. The contractor must not provide information to parents/guardians of minors or incompetents when the services are related to the following diagnoses:

- Abortion
- Alcoholism
- Substance Abuse

- Venereal Disease
- AIDS

12.3. The term "minor" means any person who has not attained the age of 18 years. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed the representative without specific designation by the beneficiary. Therefore, for beneficiaries who are under the age of 18 years or who are incompetent, a notice issued to the parent or guardian, under established TRICARE procedures, constitutes notice to the beneficiary.

12.4. If a beneficiary has been legally declared an emancipated minor, they are to be considered as an adult. If the beneficiary is under18 years of age and is (or was) a spouse of an active duty service member or retiree, they are considered to be an emancipated minor.

13.0. DOCUMENTATION

The contractor shall develop and implement a program for providing beneficiaries and providers with the written results of all review activities affecting benefit determinations. All notifications to beneficiaries and providers shall be completed and mailed within the time limits established for the completion of reviews in this section. Notifications of denials shall include: patient's name, sponsor's name and *last four digits of their* social security number, the clinical rationale for denial of payment for specific services (form letters are unacceptable as the clinical rationale shall provide a complete explanation, referencing any and all appropriate documentation, for the cause of the denial), all applicable appeal and grievance procedures, and the name and telephone number of an individual from whom additional information may be obtained.